

# PRECONCEPTION / INTERCONCEPTION TOOL

Agency: \_\_\_\_\_

Contact name: \_\_\_\_\_

Contact email: \_\_\_\_\_

1. What clinical services does your family planning program offer?

Type or write an "x" in the box of all that apply.

- |  |   |
|--|---|
| <input type="checkbox"/> Testing/treatment for sexually transmitted diseases<br><input type="checkbox"/> HIV testing<br><input type="checkbox"/> HIV treatment<br><input type="checkbox"/> Pelvic examination<br><input type="checkbox"/> Breast examination<br><input type="checkbox"/> Pap smears<br><input type="checkbox"/> Wet mounts<br><input type="checkbox"/> Treatment for abnormal Pap smears<br>(colposcopic evaluation, cryosurgery, and biopsy)<br><input type="checkbox"/> General physical examination<br><input type="checkbox"/> Contraceptive counseling/contraceptive methods<br><input type="checkbox"/> Hepatitis screening<br><input type="checkbox"/> Hepatitis vaccination<br><input type="checkbox"/> HPV Vaccination<br><input type="checkbox"/> Herpes testing<br><input type="checkbox"/> Hematocrit/Hemoglobin | <input type="checkbox"/> Measles testing<br>Chicken pox<br><input type="checkbox"/> testing<br>Rubella<br><input type="checkbox"/> vaccination<br><input type="checkbox"/> Tdap vaccination<br>Varicella<br><input type="checkbox"/> vaccination<br>Influenza<br><input type="checkbox"/> vaccination<br><input type="checkbox"/> Thyroid testing<br><input type="checkbox"/> Diabetes testing<br><input type="checkbox"/> Cholesterol testing<br><input type="checkbox"/> Anthropometric testing<br><input type="checkbox"/> Semen analysis<br><input type="checkbox"/> Genetic testing. List types:<br>_____<br>_____<br>_____<br>_____<br><input type="checkbox"/> Other:<br>_____ |
|--|---|

2. Are any of the following health issues included on your **initial** or **annual** patient history forms?

Type or write an "x" in the box for the form on which the issue is included.

Initial history form	Annual history form	Not on either form	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Isotretinoins (e.g., Accutane)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anti-epileptic drugs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dental problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Folic Acid Deficiency
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypothyroidism
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Maternal phenylketonurea (PKU)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia/Trait
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rubella, mumps, chicken pox exposure/seronegativity
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Obesity

- |                          |                          |                          |                                 |
|--------------------------|--------------------------|--------------------------|---------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Oral anticoagulants             |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | STD                             |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Smoking                         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Domestic Violence               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Drug and alcohol abuse          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Emotional and sexual abuse      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eating disorders                |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Anxiety/depression              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | History of chronic disease      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Infectious diseases             |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Environmental exposures         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Multivitamin and supplement use |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Obstetrical history             |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Immunizations                   |

3. When staff at your clinic talk with patients **with a positive pregnancy test**, do they provide information about any of the following health issues?

Please indicate whether information about these health issues is provided verbally, in writing, or not provided.

- | Provided verbally        | Provided in writing      | Not provided             |                                       |
|--------------------------|--------------------------|--------------------------|---------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Folic acid supplementation            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Vitamin supplementation               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes and glycemic control         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Healthy nutrition, weight and fitness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dental care                           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic disease management            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Environmental toxins                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Domestic violence                     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Smoking, alcohol and drug use         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Prescription medications              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sexually transmitted diseases         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Toxoplasmosis                         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Trisomy 21/Down syndrome              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tay Sachs                             |

4. When staff at your clinic talk with patients who are **currently trying to become pregnant or planning conception within a year**, do they provide information about any of the following health issues?

Please indicate whether information about these health issues is provided verbally, in writing, or not provided.

- | Provided verbally        | Provided in writing      | Not provided             |                            |
|--------------------------|--------------------------|--------------------------|----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Folic acid supplementation |

- |                          |                          |                          |                               |
|--------------------------|--------------------------|--------------------------|-------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Vitamin supplementation       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes and glycemic control |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diet, weight and fitness      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic disease management    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Domestic violence             |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Smoking, alcohol and drug use |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Prescription medications      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sexually transmitted diseases |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Toxoplasmosis                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Trisomy 21/Down syndrome      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tay Sachs                     |

5. Do staff at your agency offer preconception and interconception care information to patients **other than those** who are pregnant, currently trying to become pregnant, or planning pregnancy within a year?

No

Yes → Please explain:

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6. Does your agency provide referrals to programs or organizations (either in-house or external) for sources of preconception and interconception care? (for example, smoking cessation, nutrition or substance abuse programs)

No

Yes → Please list referral programs or organizations below:

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7. Does the family planning program at your clinic have a written protocol dedicated to preconception and interconception health care?

Yes

No

Don't know

8. Do you have posters or other visual aids in the clinic that address any aspect of preconception and interconception care?

Yes

No

Don't know

9. Do you offer preconception and interconception health care information through any classes offered by the family planning program?

Yes

No

Don't know → Skip to Question 11

10. Describe the classes offered, including the name(s) of classes and content discussed.

Name of class	Content
1.	
2.	
3.	
4.	

11. Do you offer preconception and interconception health care information at health fairs or other community events?

Yes

No

Don't know → Skip to Question 13

12. Please list the types of events at which information is offered, the method of delivery (e.g. presentation, brochures) and health topics covered.

Type of event	Method	Topics
1.		
2.		
3.		
4.		

13. Have staff at your clinic received any type of education or training about preconception/interconception care?

Yes

No

Don't know → Skip to Question 15

14. List the titles of staff who have received education or training about preconception and interconception care and the type of training (e.g. workshops, lecture).

Staff job title	Type of training
1.	
2.	
3.	
4.	

15. Do you have staff that you would like to receive training in patient education for preconception and interconception care?

Yes

No

Don't know → Skip to Question 18

16. List the job titles of the staff that would attend.

17. List topics that you would like to have discussed.

18. There can be many reasons why an organization has not integrated preconception and interconception care into their family planning program. We would like to better understand which reasons apply to your agency.

Type or write an "x" in the box of all that apply.

This question does not apply to me - we have a program

Lack of time to discuss information with clients

Lack of financial resources to pay for staff time

Lack of financial resources to pay for educational materials

Lack of providers for referrals

Need for staff training

Other reason (please explain): \_\_\_\_\_

19. Is there any other information that you'd like us to know about your program of information that you think would be helpful for the assessment?

